Marriage guidance counselling in a group practice

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SUMMARY. This paper describes the work of a marriage guidance cousellor in a group-practice centre. The considerable advantages to patient, doctor, and counsellor of her close association with the primary medical care team are discussed.

Introduction

An ever increasing number of marriages in England and Wales end in divorce and a considerable proportion of the anxiety, depression, and general ' dis-ease ' presenting in general practitioners' consulting rooms is set against a background of disturbed inter-personal relationships. Chester (1971) discovered that 130 out of 150 women preparing for divorce had found their health affected and 101 had consulted their general practitioner, usually about symptoms normally attributable to psychosomatic disease.

It is apparent, therefore, that the sensitised general practitioner prepared to spend time identifying the aetiology of these commonly presenting illnesses, will discover many patients whose main problem is marital disharmony. Evidence of the importance of marriage guidance to general practitioners is provided by Metcalfe (1970) who described a marriage guidance counsellor and general-practitioner discussion group, and Sandford (1974) who has written a series of papers on marriage guidance counselling in a medical periodical.

Method

Our practice has already accepted the concept of the ' greater team ' beyond the purely medical team of doctor, nurse, health visitor and midwife with supporting clerical staff. The ' greater team ' includes the other caring agencies—social services, the church, and disablement officers. Practice lunches at which the doctors had entertained firstly the local clergymen and secondly social workers had proved successful and had been followed by the establishment of continuing formal and informal links. A similar function resulted in the attendance of a marriage guidance counsellor at the surgery at set times during the week to see patients of the practice referred to her by the doctors.

Fairly long-standing cross-representation between the committee of the local marriage guidance council and the local medical committee helped official acceptance of the experiment.

Results

Initially it was decided to offer two counselling hours per week (i.e. two appointments). This rapidly proved inadequate and by the end of the first year the time was increased to six hours. In addition two evening appointments for patients of the practice were arranged at the marriage guidance council centre in order to accommodate clients in full-time occupations.

During the first 12 month period, 160 appointments were booked. Seven first appointments were not kept. Referrals were made by one doctor only for the first few weeks, but by the end of the first year not only were all the doctors making referrals but so also were other members of the para-medical ream.

Twenty-one marriages were represented and the clients came from every social class. The age range varied from 20–53 years. Infertility, desertion, infidelity, sexual dysfunction, physical violence, alcoholism, and depression were some of the more commonly presenting problems.

The average time given to each marriage was 11 hours and this is higher than in the marriage guidance council centre. Two clients had a single session and were not interested in more than practical information, but a couple with problems which included sexual dysfunction had a total of 15 hours.

Discussion

(1) *Advantages to the patient*

A small proportion of people with marital disharmony seek marriage guidance counselling. Many patients look to their general practitioners for such advice and Chester (1971) considered that the general practitioner was likely to be the first ' official ' helper that a woman met. Many patients present their request in somatic or psychiatric terms. The prime advantage to the patient of having a marriage guidance counsellor immediately available to the family doctor, is that they get to the ' right ' agency through the ' wrong ' door. The doctor's role following the uncovering of the aetiology of the ' dis-ease ' presented to him, is to ' sell ' the concept of counselling to the patient. He can sometimes identify the ' dis-ease ' emanating from marital disharmony at an early and more remedial stage. In particular he can recommend the individual counsellor from his own personal knowledge of her qualities.

Marital disharmony can produce organic or fairly important psychiatric illness and the patient receives the benefit of effective medical therapy concomitantly with the counsellor's attempt to remedy the underlying aetiology.

The patient finds the familiar consulting room with its safe and confidential environment a desirable atmosphere in which to receive help.

(2) *Advantages to the doctor*

Doctors are not trained in marriage guidance counselling and this can make such consultations difficult and time consuming. To have a trained expert to whom they can refer saves their own time but also increases the therapeutic benefit. Many patients who were previously frequent and time-consuming consulters of their doctor decreased their demands on his time once counselling was undertaken. Some of them took fewer psychotropic drugs. If the doctor does undertake counselling this competes with the time that he has available to practise his clinical skills.

Just as the sharing of the care of the chronic, old, house-bound patient with well-trained nursing sisters had relieved the doctor of a considerable burden, so with the sharing of the care of the miserable, unhappily married patient with another expert has lightened his workload.

The presence of the counsellor in the practice once a week at the morning meeting heightens the doctor's sensitivity to patients' problems in this area. Forgetting that marital disharmony and disturbed interpersonal relationships are common causes in so many ' dis-eases ' in general practice is frequent in clinically-trained and orientated doctors.

(3) *Advantages to the marriage guidance counsellor*

The greatest advantage to the counsellor was the awareness of being part of a caring team. Although previously she had felt little sense of isolation or narrowness of perspective when working entirely with people from her own discipline, when she became exposed to doctors, nurses, health visitors, and social workers her feeling of being an integral part of the caring services was considerably heightened. This improved her job satisfaction. She also shared that feeling of closeness to the community that is the norm for the primary medical care team.

The ' greater team ' includes social workers and members of the local clergy and she has been able to appraise these peoples' attitudes and skills and use them as an adjunct to her own. The group practice centre has proved a neutral ground on which she could liaise with the other caring agencies.

As to the counselling, the ' reception ' element of her work, by which is meant the appreciation by the patient that counselling would be beneficial, has already been undertaken and concluded by the doctor. The doctor to some extent filters her clientele.

Because of the joint care by both doctor and counsellor, the counsellor can feel more sure that the medical and psychiatric needs of the client are being adequately met. If deterioration takes place in these aspects there is a greater ease of contact. It also sensitises the counsellor

to the fact that illness can present as a marital problem, and in her work outside the group practice centre she can refer clients to their doctors more accurately. Similarly, she is increasingly sensitised to the fact that marital problems can produce clinical illness.

The doctor's contact with his patients and their families is frequently over a considerable period and the counsellor can hear the long-term results of her counselling.

The counsellor felt she received cases at an earlier stage. The majority of patients referred had no intention of having counselling when they consulted the doctor. The small number of first appointments which were not kept and the higher average time given to each marriage suggests that clients referred from their doctor entered into deeper relationships with the counsellor than clients applying directly to the marriage guidance centre.

Conclusion

This co-operation between a marriage guidance counsellor and a group practice team started as an experiment. It has proved highly successful and is now formally continuing. Both doctors and counsellor would feel the loss of an important co-worker if this co-operation was ended, and the patients of the practice would be the poorer for it.

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